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About the cover...

The American College of Surgeons is opening a new door to better, more targeted communication with and among its membership by undertaking the creation of a Web portal. The Web portal project is in the development stages now, with George F. Sheldon, MD, FACS, signing on as Editor-in-Chief (see page 28). Thomas R. Russell, MD, FACS, ACS Executive Director, provides details about the goals and objectives of this long-term project in “From my perspective” on page 3.

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NEWS

Dr. Sheldon named Editor-in-Chief of ACS Web portal project

Dr. Casey to oversee Operation Giving Back

Past-Presidents, Jacobson awardee named RCS(Eng) Honorary Fellows

College issues revised Statements on Principles

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Fellows in the news

Advances in Trauma seminar scheduled for December

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NTDB™ data points: “A is for airway”

Richard J. Fantus, MD, FACS, and John Fildes, MD, FACS

Chapter news

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From my perspective

It is often said that the key to a sound and productive relationship of any sort is communication, communication, and more communication. Hence, a professional organization like the College cannot engage in too many exchanges with its members.

Of course, the focus and formats of these interactions must keep pace with changing technology, as well as with the evolving expectations of the membership. At one time, the College conducted most communication activities through the print media, publishing the Bulletin, the Journal of the American College of Surgeons, newsletters, and letters to the Fellowship. While these materials have continued to be important means of getting information to our members, in the last decade, we also have been reaching out electronically through our weekly electronic newsletter ACS NewsScope and through regular legislative alerts sent via e-mail. As our society becomes more computer literate and the “information superhighway” widens, we are finding even greater opportunities to interact with our members and to act as a conduit for them to share their opinions and information with policymakers and the public.

Your valuable input

Communication, of course, is a two-way street, so besides providing information to our members, we have listened to them so that we can learn about and respond to their perspectives and concerns. Committees and individual surgeons have offered valuable constructive criticism and ideas with respect to how the College can better fulfill the needs of modern surgeons.

As an example, the College formed the American College of Surgeons Professional Association (ACSPA) in response to recommendations from the Board of Governors that the College develop a political action committee. The loud and emotional pleas from our rank-and-file membership regarding our need to take the lead in achieving medical liability reform spurred the ACSPA to help establish Doctors for Medical Liability Reform and to direct some significant resources into other efforts to create a political environment that will encourage this type of change.

This year, the College has become more attentive to hearing the point of view of residents and Associate Fellows. Claude H. Organ, Jr., MD, FACS, declared this, his Presidential year, to be the year of the resident—a timely pronouncement given the increasing educational, financial, and lifestyle demands on surgeons in training. It is absolutely key to the survival and growth of this organization and this profession that we understand and support the concerns of young people, beginning when they are medical students and continuing throughout their residency and entry into practice.

In response to the building concerns that residents and young surgeons have been expressing, we have activated the Resident and Associate Society of the ACS (RAS-ACS), formerly the Candidate and Associate Society of the ACS. The RAS-ACS publishes a quarterly electronic newsletter spotlighting the interests of its membership. Additionally, members of the RAS-ACS have been invited to participate in the activities of the Board of Regents, the Board of Governors, and other committees, thereby allowing them to voice their opinions directly to the College’s leadership. We anticipate that by offering them these types of positions within the organization, they will have opportunities to hone the skills they will need to assume leadership roles within their institutions and the College in the future.
Web portal

It is in this spirit of listening to the pleas of our members that the College has taken very seriously a suggestion from the RAS-ACS and the Committee on Young Surgeons that a new electronic communications tool be developed for all of our members. Thus, in June, the Board of Regents approved in concept and with financial support the creation of a Web portal for its membership, which the young surgeons assert is necessary to enhance communication and interaction between the College and its Fellowship in this computer age. We anticipate that this exciting new communications tool will be launched next summer.

For those of you who are unfamiliar with the term, a Web portal is sort of a personalized gateway or entry point to the Internet. It serves as a quick and easy method of accessing material that is tailored to an individual’s interests, whether they lie in the clinical arena, in business processes, in politics, in academics, or in other areas. Through a portal, the user is able to identify exactly what he or she wants to know about, and the individual’s homepage is automatically populated with information on that subject as soon as it becomes available.

The goals and objectives of this program are to: (1) improve and extend the relationship between members and the College; (2) unify the various College Web sites into an integrated presence on the Internet; (3) allow the members to customize what they see when accessing the College through the Web; (4) simplify the process for members to access information; and (5) build specialized communities of the members.

Initial priorities include making it possible to access the College’s Web activities by using a single login, posting a calendar of events and programs sponsored by the College and other organizations, and developing a program that will enable surgeons to conduct a federated search of both College and non-College publications. We also intend to provide online access to materials of interest to our members, assist surgeons who want to keep a portfolio of their continuing medical education activities, disseminate legislative and advocacy alerts, and conduct quick polls on relevant issues.

Subsequently, we anticipate that the Web portal will support a variety of “e-learning” programs, serve as a repository for surgeons who want to record and track their cases to support practice-based learning activities, and allow surgeons to share with patients information about their practices and outcomes. Eventually, we may well see the establishment of “virtual” communities, with electronic bulletin boards and e-mail list serves to draw like-minded surgeons together.

Enormous, cooperative undertaking

Obviously, it will take years to bring this project to complete fruition, but the seeds are already germinating. We have appointed ACS Past-President George F. Sheldon, MD, FACS, to serve as Editor-in-Chief of the project (see story, page 28) and have hired a managing editor. We will need volunteers from all of the surgical specialties to assess the types of information that will be most useful to our membership. We also will rely on the Advisory Councils for the Surgical Specialties, the College’s divisions, the Communications and Information Technology staffs, the Committee on Informatics, and others to make this program work. Eventually, we will need industry support as well.

This is a very exciting project, and we are thankful to the RAS-ACS and the Committee on Young Surgeons for recommending it on behalf of the entire membership. I also would like to acknowledge the efforts of the task force that has drawn the blueprint for this project, which was headed by Richard J. Finley, MD, FACS. Linn Meyer, ACS Director of Communications, Howard Tanzman, ACS Director of Information Technology, and the Committee on Informatics also played key roles.

Stay tuned for the launch of this important and innovative program, which I believe will benefit us all.

Thomas R. Russell, MD, FACS

If you have comments or suggestions about this or other issues, please send them to Dr. Russell at fmp@facs.org.
ONLINE CME: Courses from the American College of Surgeons’ Clinical Congresses are available online for surgeons. The online courses feature printable written course transcripts, audio of sessions, video of the introduction of each session, post-test and evaluation, and printable CME certificates upon successful completion. Several of the courses are offered FREE OF CHARGE. The courses are accessible at: www.acs-resource.org.

BASIC ULTRASOUND COURSE: The ACS and the National Ultrasound Faculty have developed this course on CD-ROM to provide the practicing surgeon and surgical resident with a basic core of education and training in ultrasound imaging as a foundation for specific clinical applications. It replaces the basic course offered by the ACS and is available for CME credit.

BARIATRIC SURGERY PRIMER: Developed by Henry Buchwald, MD, PhD, FACS, and Sayeed Ikramuddin, MD, FACS, the primer addresses the biochemistry and physiology of obesity; identifies appropriate candidates for bariatric surgery; and discusses the perioperative care of the bariatric patient, basic bariatric procedures, comorbidity and outcomes, surgical training, and the bariatric surgical and allied sciences team, along with facilities, aspects of managed care, liability issues, and ethics.

SYLLABI SELECT: The content of select ACS Clinical Congress postgraduate courses is available on CD-ROM. These CD-ROMs are able to run in the PC and Mac environments and offer you the ability to word-search throughout the CD, along with the convenience of accessing any of the courses when you want, and where you want. The 2004 CD will be available in October.

PERSONAL FINANCIAL PLANNING AND MANAGEMENT for Residents and Young Surgeons: The CD uses an interactive/lecture format to arm surgeons with basic financial management skills. The course is designed to educate and equip young surgeons with the knowledge to manage their personal financial future, including debt management, preparation for significant life events (such as retirement or college education of their children) and proper planning for financial stresses related to their surgical practice.

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For more information contact Dawn Pagels, MBA, at dpagels@facs.org, or tel. 312/202-5185.
Dateline Washington

prepared by the Division of Advocacy and Health Policy

**CMS eliminates coding grace period**

Over the next few months, Medicare providers will no longer have a 90-day grace period to convert to the new Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and ICD-9-CM codes. Use of discontinued codes will result in nonpayment. This policy is the result of Medicare’s efforts to enforce a standard set forth in the Health Insurance Portability and Accountability Act (HIPAA), which requires providers to report codes that are valid when the service is rendered. The annual effective dates are October 1 for ICD-9-CM codes and January 1 for CPT/HCPCS codes.

**CMS proposes policy on emergency services**

The Centers for Medicare & Medicaid Services (CMS) called for comments on a proposed implementation plan to pay for emergency services furnished by physicians, hospitals, and ambulance services to undocumented aliens. The most controversial aspect of the plan would require immigrants to indicate their citizenship status. Advocates for undocumented aliens are asking CMS to revise the proposal, arguing that the current plan would cause these individuals to forego needed medical care for fear of deportation.

In comments submitted August 16, the College favored using the information that the hospital already gathers during the financial screening process as an indicator of citizenship status. The College also favored CMS’s approach to paying for emergency care and any related inpatient care and suggested that funding for these services not be used for unrelated care.

Finally, the legislation provided hospitals with the option of receiving payment for both the hospital and physician services, reimbursing the physicians for their services, or allowing payments to go separately to the hospital and the physician. Surgeons will urge their hospitals to allow payments to go directly to physicians. These provisions were included in the Medicare Prescription Drug, Improvement, and Modernization Act (MPDIMA). Most of the money will be spent in Arizona, California, Illinois, New York, and Texas.

**Medicare announces 2005 premium and deductibles**

The Department of Health and Human Services (HHS) recently announced increases in Medicare beneficiaries’ premiums, deductibles, and copayments. For Medicare Part A, which pays for inpatient, skilled nursing, and some home health care services, the inpatient hospital deductible will be $912 in 2005. This amount is an increase of $36 from 2004’s $876 deductible, which is the only cost patients pay for up to 60 days of care. The annual Part B premium, which covers physician services, outpatient hospital care, and some home health services, as well as durable medical equipment, will be $78.20, an $11.60 increase from the 2004 cost of $66.60. The MPDIMA requires raising the Part B deductible to $110 in 2005 and indexing it thereafter based on the average cost of Part B services for the aged.

HHS claims that several factors have contributed to these price increases:

- Higher payments for services provided under Medicare’s tradi-
tional plan, including a 1.5 percent increase in physician reimburse-
ment.
• Improvements in both the traditional and the Medicare Advan-
tage (Part C) program, which will provide additional benefits, includ-
ing prescription drug coverage, more preventive care, and dental and
vision coverage. In addition, the new preventive benefits provided un-
der the Act will cover the cost of a “Welcome to Medicare” physical, as
well as screening for heart disease and diabetes.
• A need to increase the reserves held in the Part B account in the
Medicare Supplementary Medical Insurance Trust Fund.

NIH offers student loan repayment

The National Institutes of Health offers a series of loan repayment
programs for participants with doctoral degrees who devote 50 percent
or more of their time to research funded by not-for-profit organiza-
tions or government entities. To qualify, individuals also must have
educational loan debt that is equal to or greater than 20 percent of
their base salary. Loan repayments are available for research in the
following areas: clinical care, services for individuals from disadvan-
taged backgrounds, contraception and infertility, health disparities, and
pediatric care. Applications for the awards are due December 15 and
are available by visiting www.lrp.nih.gov.

Dr. McGinnis appointed to NQF panel

LaMar S. McGinnis, Jr., MD, FACS, Vice-Chair of the College’s Health
Policy Steering Committee, has been appointed to the National Quality
Forum’s Cancer Data and Methods panel. The group is charged with
developing criteria for the types of data that the NQF cancer panels
should use to formulate quality of cancer care measures that will be
available for clinicians and consumers.

American hospitals reporting quality data

The American Hospital Association, the Federation of American
Hospitals, the American Association of Medical Colleges, and the
CMS have partnered to develop a Hospital Quality Initiative. The
program is intended to improve the quality of hospital care across
the nation and to provide consumer and clinical performance inform-
ation on 10 standards of care for the treatment of heart attack,
heart failure, and pneumonia. The MPDIMA provided a financial
incentive for hospitals to report quality data by linking it to pay-
ments they will receive for treating Medicare beneficiaries. While
voluntary, those inpatient hospitals that fail to report will receive a
0.4 percent reduction in their annual Medicare fee schedule update.
More than 98 percent of the 3,906 eligible hospitals have met all of
CMS’s quality reporting requirements and will receive full payment
from Medicare in 2005. Hospitals are tracking key steps in what
clinicians feel is appropriate care.

By 2005, CMS plans to make this quality information available to
consumers through its Web site, www.cms.hhs.gov, or by calling 1-800/
MEDICARE.
What surgeons should know about...

What’s wrong with the SGR

by Cynthia A. Brown, Director, Division of Advocacy and Health Policy

Following a 5.4 percent reduction in 2002 Medicare reimbursements for physician services, Congress passed two bills last year that blocked similar pay cuts in favor of modest increases in 2003, 2004, and 2005. Nonetheless, when the 109th Congress convenes in January, surgeons will once again face the challenge of convincing their legislators that they need to take action to avert the significant Medicare payment reductions projected for 2006 and subsequent years.

As the College prepares for this effort, many surgeons must wonder why this situation is happening again. Clearly, the current arrangement is unsustainable; after all, general practice costs and liability premiums have been escalating. What problems lie at the root of this dysfunctional payment system? Why has Congress implemented stop-gap measures rather than a permanent solution?

The following questions and answers are intended to help surgeons better understand the Medicare payment system and the obstacles they and their legislators confront in designing effective reforms.

What is the sustainable growth rate (SGR)?

The SGR is a cost-containment mechanism intended to restrain the rate of growth in Medicare spending for physician services. It is a prospectively determined expenditure target that is used, in part, to determine the annual update to the Medicare fee schedule conversion factor.

How does the SGR work?

Normally, payments for goods and services purchased by Medicare are updated annually by an inflation factor. If the same were true for physicians’ services, the conversion factor that translates the relative value units (RVUs) in the Medicare fee schedule into service payment amounts would be updated each year by the Medicare Economic Index, or MEI.

For physicians, however, the aggregate rate of Medicare spending growth under the fee schedule in a given year is compared to the SGR. If spending growth is below the SGR target rate, commensurate “bonus” percentage points are added to the MEI to determine the annual update in a subsequent year. On the other hand, when aggregate spending exceeds the SGR the excessive percentage amount is deducted from the MEI. Regardless of how much actual spending falls short of or exceeds the SGR, Medicare law limits penalty deductions to no more than seven percentage points below the MEI, and bonus increases can be no more than three percentage points above the MEI.

Table 1 on page 9 shows how this system would have worked to determine the 2005 conversion factor, if Congress had not mandated an update of at least 1.5 percent.

What factors are used to set the SGR?

The SGR is calculated according to a formula that accounts for annual changes in the following factors: (1) the cost of providing services, as measured by the MEI; (2) real per capita gross domestic product (GDP) growth; (3) the number of Medicare fee-for-service beneficiaries; and (4) the effect of new laws and regulations (for example, the addition of new congressionally mandated program benefits, such as colorectal cancer screening).
For the past few years, we’ve heard that the SGR would have mandated negative fee schedule updates—with resulting across-the-board payment reductions—if Congress had not intervened. What is causing this downward spiral in payments?

The structure of the SGR itself and current trends in spending and economic growth are causing the system to produce negative updates. More specifically:

• Service volume is growing. After being relatively stable for a number of years, growth in the volume and the intensity of services covered by the SGR have been increasing rapidly, exceeding the annual targets. While rates of spending growth for most surgical services are comparatively low (and even declining for some), the volume of many other invasive and imaging procedures is growing rapidly (see Figure 1 on this page).

• Lower rates of GDP growth. The problem is exacerbated by lower rates of GDP growth in recent years. Under the SGR formula, if Medicare service volume and intensity grow faster than the national economy on a per capita basis, the annual fee schedule update will be less than the estimated increase in the cost of providing services. Currently, the national economy is growing at a rate of about 2 percent each year. In comparison, the Centers for Medicare & Medicaid Services (CMS) actuaries estimate that the rate of spending growth for Medicare physician services in 2004 will be nearly 9 percent.

• Cumulative spending. The SGR is cumulative in nature. In other words, SGR adjustments are determined by how much the cumulative amount of actual spending on physician services since the base year of 1996 differs from the cumulative spending target since that year. As a result, the system requires that excess spending in any

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<td>Current estimate of 2005 fee schedule conversion factor</td>
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<td>CY 2004 conversion factor</td>
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<td>MEI</td>
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<td>SGR performance adjustment</td>
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<td>Other factors</td>
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<td>Calculated increase</td>
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<td>Calculated 2005 conversion factor</td>
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<tr>
<td>Actual increase mandated by law</td>
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<td>Estimated 2005 conversion factor</td>
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single year be recouped in future years. The only way to achieve this objective is to reduce the fee schedule updates enough to offset the excess spending. With a “floor” on payment updates of MEI –7 percent, it can take quite a few years to offset a period of high spending growth.

- “Incident to” services. Spending growth rates are extraordinarily high for items and services that are provided “incident to” a physician visit, such as diagnostic laboratory services performed in the office and physician-administered drugs. Arguably, rates of spending growth for these items do not belong under the spending target because their costs are not paid under the fee schedule and their prices are not influenced by the SGR. While these items do not account for the majority of Part B spending under the SGR, their rate of expenditure growth far outpaces the growth in physician services.

- Site of service shifts. The trend toward providing more services in outpatient and office settings is increasing fee schedule costs covered by the SGR to a degree that is underappreciated and difficult to quantify. This trend is probably most noticeable for those services that are experiencing the most rapid rates of growth, such as diagnostic imaging. Medicare pays more for services when they are provided in a physician’s office to reflect the fact that the physician personally incurs greater overhead costs (see Table 2, this page).

Interestingly, services formerly provided in a hospital or other facility no longer result in a separate facility payment when they are provided in a physician’s office setting. As a result, higher physician payments for office-based services should be offset to a significant degree by foregone facility payments covered elsewhere by Medicare Part A (for former inpatient services) or Part B (for hospital outpatient and ambulatory surgical center services). Unfortunately, the current physician payment system lacks a mechanism for “transferring” such savings into a larger spending allowance under the SGR. Consequently, existing trends (and incentives) to provide more services in the office setting contribute to the fee schedule spending increases that are producing the downward spiral in payments for physician services across the board.

How long is this series of cuts expected to last and how bad is it going to get?

CMS currently estimates that without a change in law the current system will produce negative payment updates annually through 2013. For the first several years, these reductions will reach the maximum threshold of MEI less seven percentage points.

Didn’t the College support expenditure targets in the early 1990s when the Medicare fee schedule was first implemented? What has happened since then?

When the law was written that established the Medicare fee schedule in 1992, the College en-

<table>
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<th>CPT 19120—Removal of Breast Lesion</th>
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<tr>
<td>2004 facility payment: $385.12</td>
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<tr>
<td>2004 nonfacility (office) payment: 446.28</td>
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<tr>
<td>Difference: 61.16 (15.9%)</td>
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endorsed the concept of Medicare volume performance standards, or MVPSs. Although these, too, were expenditure targets, they differed from the SGR in significant ways. For example, separate MVPS targets were ultimately established for three service categories—surgery, primary care, and other physician services. This minimized the impact that service volume growth in one service area would have on payments for completely unrelated services.

Other ways in which the MVPSs differed from the SGR were as follows: (1) cumulative spending was not a factor in determining the impact of the MVPSs on annual updates because they covered only a single year; (2) recent trends in actual Medicare spending on physician services were used instead of GDP growth as a gauge of health care needs; and (3) the Secretary of Health and Human Services had discretion to modify the targets to reflect changes in technology, costs, and so forth.

As a result, the MVPS system was not only more flexible, but, because of relatively slow service volume growth in surgical services, it produced far more favorable fee schedule updates for surgeons. Between 1992 and 1997, when the separate MVPSs were in effect, the conversion factor for surgical services grew from $31 to $40.96 (compared to the current 2004 conversion factor of $37.34).

What is the solution to our current problems with the Medicare payment system?

Clearly, the SGR is a blunt instrument for controlling Medicare physician expenditures. Over the years, it has produced relatively low rates of spending growth for physician expenditures and, hence, some budget watchers consider it “successful.” However, the indiscriminate nature of the reductions produced by the SGR certainly argues against its utility from a policy perspective. And, as a practical matter, it stands to reason physicians can only absorb so many annual payment reductions before they simply cannot afford to provide some important health care services. The optimal solution is to establish an update system that is based on the actual changes in the cost of providing physician services, so that those physicians who provide needed care are spared any penalties. The challenge, of course, is to address questions about inappropriate payment incentives and ineffective patterns of care that are driving service volume and program costs to levels the federal government (and other payors) can no longer afford.

What stands in the way?

Eliminating the SGR is an expensive proposition. Because of the “baseline” spending trends, it was estimated last year that replacing the current payment system with one based on the MEI (annual Medicare inflation rate) alone would cost nearly $100 billion over 10 years. More recent estimates set the price tag at closer to $200 billion. Given the size of the federal budget deficit, Congress will need to make some difficult choices before it can make this amount of money available for a physician payment fix. CMS and the Administration could help by making certain regulatory changes that will lower the cost of a congressional solution. Finally, organizations like the College can contribute by devising sound proposals that incorporate principles that promise to achieve needed cost controls by improving the value and effectiveness of the care that patients receive, such as evidence-based medicine.
How will limitations imposed on residents’ work hours affect medicine?

by

Martin B. Camins, MD, FACS,
New York, NY;

Beth H. Sutton, MD, FACS,
Wichita Falls, TX;

and

John M. Daly, MD, FACS,
Philadelphia, PA
In 1989, the New York state legislature enacted New York State Code 405 in response to the 1984 death of a female patient at New York Hospital. A report by the Bell Commission implicated the rigors of resident training as a part of the problem that led to this tragic death and issued recommendations for graduate medical education reform. More specifically, the commission cited overwork, sleep deprivation of house staff officers, and lack of supervision as major issues requiring corrective measures.

Since the state's rules went into effect in 1989, hospitals in New York State have attempted to adhere to them. However, a 2002 audit of the state's teaching hospitals indicated that 63.6 percent were noncompliant. The most common infractions were: (1) having residents work in excess of 24 consecutive hours; and (2) having residents work in excess of 80 hours per week.

Similar requirements were imposed nationally when, after considerable debate and input, the Accreditation Council for Graduate Medical Education (ACGME) on June 12, 2002, issued rules limiting residents' work hours. These changes have altered the fundamental manner in which future U.S. residents will be trained.

The objective of these new standards is to maintain the high quality of clinical and didactic education while simultaneously improving patient safety. Provisions are included for institutional monitoring and oversight.

In addition, the Patient and Physician Safety and Protection Act of 2003 was introduced in Congress by Sen. Jon Corzine (D-NJ) and Rep. John Conyers (D-MI). This legislation became effective July 1, 2003, and called for the development of regulations to address public concerns about the deleterious effects that sleep deprivation could have on patient and house staff officer safety, patient well-being, and resident education. These new regulations dictate a minimum standard that must be achieved by all accredited training programs. A further attempt to enforce the system for monitoring compliance was made as well.

The restrictions imposed on residents' work hours limit their schedule to 80 hours per week, although a department chair may petition to increase this limit by up to 10 percent if a sound educational rationale is offered. Additional mandates include at least one night out of seven free time, no more than one night on call every three nights, and a maximum work duration limit within a given shift. These new rules also grant a minimum resting period of 10 hours between patient care shifts. Teaching hospitals and individual specialties are encouraged to develop innovative programs to support and monitor the emotional and physical well-being of residents and to promote an educational environment that leads to safe patient care.

Over time, the ACGME hopes to gather information from the New York State experience to support the thesis that working excessively long hours negatively affects the cognitive performance and function of house staff officers. Since New York State restrictions were instituted in 1989, studies have shown that patient care has neither diminished nor improved. Gradually, through prospective and retrospective studies, training programs in New York are gaining insights into the changes in residents' attitudes about the residency program modifications.

Other fields are also studying the effects of restrictions they have implemented. Studies of airline pilots have demonstrated that fatigue and sleep deprivation can decrease attention span and manual dexterity, and compromise decision making. The Federal Aviation Administration has reviewed these studies and confirmed that fatigue leads to increased anxiety, reduced motivational drive, decreased short-term memory, slower reaction time, work inefficiencies, and greater variability in work performance.

Dramatic alterations in the current design and structure of residency specialty programs must be accomplished to meet the ACGME guidelines. During a recent annual meeting of the Association of Program Directors, the department of surgery at New York-Presbyterian Hospital (Columbia Campus) presented their new system for scheduling surgical residents. Their two-team approach deviates from the norm of every third night call schedule by creating a day and night team of residents that allows for continuous daily patient care but in alternating shifts. The residents at this institution are also responsible for tracking their personal duty hours and entering them into a work-hour database. The responsibility of the senior/chief resident to moni-
itor and limit residents from working excessive hours has dramatically improved compliance. Continued restructuring and reevaluation of the workforce and graduate medical education challenges the future of medical education.

**Controversy over implementation**

Considerable debate among hospital administrators, medical directors, department chairs, and teaching program directors has arisen over the implementation of these requirements. Those individuals who concur with the new directives and regulations believe that house staff fatigue correlates directly with physician error, depression, anger, and lack of compassion for patients. These advocates for reform see benefits in adjusting on-call schedules, recruiting and educating physician extenders, and scheduling “night float” residents responsible for overseeing patient care on the evening and night shifts.

Other members of the community oppose the new regulations, arguing that more patient transfers between physician caregivers will lead to increased medical errors. The critics of these regulations emphasize that a key goal of house staff training is to engender a sense of accountability and responsibility. They also express concern over the loss of professionalism among resident physicians who regard themselves as “hourly workers.” Will these restrictions inhibit or, even worse, sever the unique bond between patient and physician that has been the foundation of our profession and the public’s perception of us?

The stress and intensity of caring for patients in teaching hospitals is far greater now than in the past, creating disturbing shifts in the attitudes of residents. House staff work-hour reforms reflect a response to changes in medical care in America, including decreased length of hospital stay, advancements in medical technology, and increased severity of illness. Innovative programs and questionnaires demonstrate that residents’ attitudes can be objectively measured and that residents can accurately perceive and respond to program modifications. Efforts can now be made to develop valid standardized attitudinal scales from such questionnaires to aid in the assessment of the numerous changes in residency programs currently being implemented. Creative solutions are needed to formulate a strategy of medical education and medical care that is based on more than just workforce demands and numerical solutions that only relate to compliance with an 80-hour week. One area that has been severely neglected is the measurement of educational goals and outcomes. How do we achieve more from this group of the “best and brightest?”

**Evaluating regulatory changes**

Politicians and administrators feel that the new 80-hour workweek limitations are a leap forward into a new era of medical training characterized by enlightenment and foresight, but others disagree. Multiple centers, initially in New York and now nationwide, are attempting to evaluate how these guidelines affect training and patient care through confidential studies of residents and program directors. In one survey, an overwhelming majority of program directors and a clear majority of residents opposed the work-hour restrictions. They said that the guidelines will have a negative impact on resident training.

A survey of residents enrolled in general surgery programs throughout New York State confirmed that most respondents attempt to comply with Code 405 regulations. Although the majority of residents find that these regulations improve their quality of life by decreasing their stress level, a significant number are convinced that the rules negatively affect their surgical training and the quality, intensity, and continuity of patient care. A predicted reduction in educational operative opportunities was considered detrimental. Concern about the transition to a shift-worker mentality was a prevalent theme. Interestingly, negative perceptions of

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**Dr. Camins** is clinical professor of neurological surgery, Mt. Sinai Hospital and Medical School, New York, NY, and a member of the Patient Safety and Professional Liability Committee. He is also a Regent of the College.
the impact of duty-hour restrictions are more prevalent among senior residents and residents at academic institutions than among junior residents at community hospitals. As reported from an in-house survey at New York Presbyterian Hospital, residents and faculty believe schedule changes have a deleterious effect on patient care.

On the other hand, the mean American Board of Surgery in-training exam scores improved significantly for junior residents after the reduction of work hours. This suggests that long work hours that result in fatigue may adversely affect residents’ study habits and preparation for cognitive functions. Yet perceptible differences were noted in test scores for senior residents. Barden and others conclude that a reduction in resident work hours has a positive effect on the perception of workload and learning environment. Further evaluation and critique is necessary to judge the long-term effects of these changes on both residents’ training and patient care.

Other surveys have evaluated the potential correlation between house staff coverage schedules and the occurrence of preventable events. Petersen and colleagues found an association between potentially preventable adverse events and coverage by physicians from another service. Laine and others found that inhospital complications and diagnostic test delays were more frequent since New York State enacted work-hour limitations. Another study from a Boston, MA, teaching hospital suggested that a tired intern with detailed information about a patient may be able to provide more appropriate care than a well-rested one who is less familiar with the case. These studies indicate that interspecialty cross-coverage by a physician from another service may hinder continuity of care plans, provide incomplete transmission of information, and cause subsequent errors in judgment by a covering physician who is unfamiliar with the details of a patient’s history.

Implementation of regulations

Multiple suggestions have been offered to address the problems caused by work-hour regulations. These include requesting that the Residency Review Committee establish more residency positions, using prep- or postresidency fellows, creating a “night float” coverage schedule, lengthening or shortening the residency program, reducing electives/research time, altering resident involvement in cases, developing more postresidency specialty fellowships, and petitioning hospitals to hire nurse practitioners and physicians’ assistants to cover noneducational duties traditionally performed by residents. Another possibility is limiting residents’ work hours by eliminating the expectation that they perform tasks that can be done by other personnel and that have no educational value.

Each option deserves further scrutiny, but certain drawbacks already are apparent. Lengthening residency seems like a simple solution, but it would be difficult to implement given current workforce concerns, financial constraints, and limited available funding. What effect would additional years of training have on the relative attractiveness of individual specialties?

Is a “night float” system the answer? Studies have demonstrated that a “night float” system (in which designated residents cover night call for a specific time period) may be more detrimental to good patient care than the present system in which the same team provides continual care. This implies that a team of physicians, although fatigued, knows a patient and the nuances of his or her care and is, therefore, better suited to upholding continuity of care than a well-rested team that is unfamiliar with the patient. The residents who are part of the “night float” system are frequently pulled from their time on research electives, which is all about education unrelated to the issues of hospital coverage.

Dr. Sutton is a general surgeon in private practice in Wichita Falls, TX, and a member of the Patient Safety and Professional Liability Committee.
Employing physician extenders is cited as another possible solution. All these choices may be realistic options for a university hospital, but where are the supplemental governmental financial resources to support these alternatives? Another question we need to consider is what type of registry is necessary for tracking resident education hours and ensuring compliance with the new regulations. Maintenance of this type of device will represent a change in the usual daily routine. Many options involving commercial time-tracking software are now being considered. Compliance remains a significant hurdle, and it is an uphill battle to get everyone to regularly use a tracking system. Residents often record their data on weekly time sheets, and then data entry is done by system administrators. The data recording and reporting feature would be the same, but the input for the residents might be easier than having them dock in and out on a desktop each day.

Conclusion

Unfortunately, the ACGME regulations raise more provocative questions than they answer. Although we need to provide appropriate medical care, we also must minimize the adverse outcomes that can occur in the caregiving process. Surgical training must continue to be about education and patient care, not about following work-hour rules. Every activity performed by a house staff officer has educational value, even those that are primarily service-oriented, because they can add to the physician’s knowledge base.

Surgeons in private practice will face many practical concerns regarding the eventual effect of ACGME guidelines on the surgical workforce. The availability of surgeons to care for patients presenting to emergency departments or needing elective consultations is a significant issue in private practice. The majority of surgeons currently practicing in both academic and nonacademic practices are extremely concerned that the new guidelines may adversely affect the expectations that young surgeons have regarding call coverage and continuity of care. Surgeons in communities throughout America feel that they have a moral and ethical responsibility to care for urgent and emergent problems, and this concept has been a very significant component of surgeons’ training. The disparity between the 80-hour workweek during residency and the expectation that hospital staff surgeons may be pressured to provide every third night on call once they enter into practice may produce some significant discontent in young surgeons entering the private workforce. These new ACGME guidelines may produce expectations of structured time off that are incompatible with the demands of private practice. Surgeons in private practice, while acknowledging the shortcomings of the traditional Halsted hierarchy training system, remain wary of the long-term effects of the ACGME guidelines.

A new curriculum for residency training must be formulated to deal with the educational objectives within the context of the 80-hour workweek guidelines. Attending surgeons in academic training centers must not become complacent. It remains their responsibility to continually strive to improve the work environment, to inject enthusiasm and pride into the workplace, and to foster residents’ educational experience. If practicing physicians do not take a proactive stand to determine the future demands of their specialties, then the rules will be made by individuals who do not understand the implications of these types of major sweeping changes.

Bibliography


Dr. Daly is dean, Temple University School of Medicine, Philadelphia, PA, and a member of the Patient Safety and Professional Liability Committee continued on page 35
This is a story of hope. It began in September 2000—before the time-stopping events that would follow a year later on 9/11, before the war in Iraq, before so many occurrences that have forever changed the world as we know it.

"Can you help?"

Our small group of missionary medical practitioners was returning to Mombin Crochu, Haiti, to the small clinic lost in the mountains of the poorest country of the poorest people in the western hemisphere. We had been there many times before and knew that each trip would open a door to new experiences, new lessons, and new problems.

As we stepped down from the single-engine mission airplane that had carried us into the mountains from Port-au-Prince, one of the hospital workers that we had come to know well was waiting for us. He was holding an X ray in one hand and grabbing my arm with the other.

"Please, Dr. Campbell, can you help?" With this question, I was introduced to Patrick, who would, over the course of the next few years, inspire and exemplify the power of hope.

Patrick was 12 years old. He had fallen off the back of an overcrowded truck, which, like all vehicles in Haiti, was packed far beyond capacity. Crushed by the wheel, he initially was taken to our clinic. No surgeon was available to see him when he was arrived, so he was transported to another facility nearby, where he was diagnosed with a severe pelvic fracture and intraabdominal trauma. A suprapubic tube was inserted, and he lay near death. Because Haiti has no government hospitals and his family has no real resources, he would be discharged home, in spite of his severe injuries.

We drove to the hospital and saw the small boy, lost in the sheets, barely responsive. The staff asked if we could help, but what could we do really? We had just arrived, we were uninformed about what was happening at the clinic, and we...
had only the equipment that we had brought on the plane. Yet how could we allow this child to be sent home to certain death?

After discussing the situation that night, part of our team returned to the hospital the next day to bring Patrick back to Mombin Crochu, where we would care for him as best we could. Using the only equipment available, an antiquated sonogram and a modification of the “FAST” technique, we were able to determine that no other obvious injuries were present. His abdomen remained benign, and because no other X-ray or laboratory facilities were available, we relied on clinical findings and physical examination, monitoring urinary output and vital signs, to draw up a treatment plan. We treated his sepsis and shock with what little we had available and prayed. Patrick would live, but more extensive care was needed if his life was to be a full one.

**Support at home**

After returning from the mission, I showed Patrick’s one X-ray to my orthopaedic colleagues, who saw an open-book-type pelvic fracture. They recommended bed rest, so that the displaced bones could heal, given that surgery was not an option at the time.

The fracture’s location suggested a probable transected urethra, and, because he found clamping his suprapubic tube intolerable, this appeared to be an accurate diagnosis. The many pediatric urologists I consulted recommended that the repair be attempted in this country, because it is a very te-
dious, difficult procedure that would not be reproducible in Haiti.

We communicated via e-mail with the clinic in Mombin Crochu, and the dialogue continued between Haiti and Tampa, FL, until Patrick’s fracture healed. However, these communications revealed that Patrick was not well. He was experiencing frequent urinary tract infections, and progress with his ambulation was slow. I knew we had to get him to the U.S., somehow, to have surgery.

**Bureaucratic hassles**

One might assume that bringing a sick child to this country would be a reasonably routine process, perhaps involving a few administrative roadblocks. But Patrick had no birth certificate, no passport, no medical visa. His parents lived apart, and traveling to Port-au-Prince to gather these documents was no simple task.

First, the birth certificate had to be obtained with signed papers from his parents and approval from a local judge. Obtaining the birth certificate alone took one year. Then he had to apply for and obtain a passport.

After all that, the paperwork for the medical visa began. To get Patrick’s medical visa, we had to submit multiple letters of support from this country, copies of my income tax returns, including all debts and assets that I had claimed, and letters of agreement that I would be responsible for any financial problems incurred as a result of his visit. This process took more than three years to complete.

Each time we returned to Mombin Crochu, Patrick would be waiting at the clinic, his brown eyes wide with anticipation of news about whether he would be able to have his operation, his hand holding the Foley catheter bag that had become part of his life, his heart full of both hope and fear.

Each time I saw him I would say, “We are trying, Patrick. We are trying so hard.” And each time I would pray that he would be allowed to return to a normal life.

Patrick was patient. He would smile weakly, and say, “Oui, doctor. Merci.”

**False start**

Finally, we were ready. The urologist, the hospital, the anesthesiologist, and everyone else involved in his treatment agreed to care for Patrick.
gratis for no reason other than it was the right thing to do. His ticket was purchased, and we planned to pick him up March 5, 2004.

Then a civil war broke out in Haiti. Rebel bands made chaos commonplace, and the missionaries at the clinic had to evacuate. We had no way to contact Patrick and tell him that the planes were not flying, that he could not come. I later learned that he had traveled, somehow, in spite of the wandering rebel bands, to Port-au-Prince. He made it to the airport only to find it empty. This story was so reflective of Haiti’s national experience: another dream deferred, leaving eyes empty in their despair. My heart broke to think of his situation.

Yet we did not give up.

He arrives

Employees of American Airlines have developed an Airline Ambassadors program, which allows volunteers to use donated frequent flyer miles to travel abroad and escort sick children to the U.S. I had learned about this program from a flight attendant on one of our trips and had saved her business card. I tried contacting her by e-mail to no avail, but was able to reach Ms. Margaret Whitehead of the Airline Ambassadors program in Atlanta, GA, by telephone, and she helped me to arrange transportation for Patrick. She connected me with Ms. Lisa McKellar, a true angel, who flew to Port-au-Prince on May 5, 2004, to bring Patrick to our country for his operation.

I waited for him at the gate, filled with wonder that he was actually coming here, in spite of so many difficulties. As Patrick and Lisa approached, I saw his torn clothes, his thin frame, and watched as he wiped away tears with his free hand. I could not imagine what he was thinking or what it was like to go through the journey that he had traveled that day. He had left a small mountain village with no electricity or running water on a jet to arrive at Tampa International Airport and be carried into the frenetic world of modern America.

Patrick became part of our family for almost six weeks. He spoke no English, but words were unnecessary.

Patrick had his surgery. Mark Swierzewski, MD, repaired his transected urethra. There was a great deal of scarring, and the urethra had retracted significantly, but it was possible to do a primary anastomosis. He tolerated everything that was
done postoperatively without complaint, remaining in the Children’s Hospital until he was stable for discharge.

Members of our church, the hospital staff, and the community all stepped in to help during both his hospitalization and his recovery. Someone was always willing to spend time with him, play games, or just be. People gladly gave of themselves to this child in need. For the first time in four years he could run, play ball, and have two free hands; he was able to look and act like a normal teenager. After three weeks, a retrograde urethrogram was performed to evaluate the anastamosis, and again his care was provided without charge.

**Life education**

Patrick learned a great deal during his time here. He learned about electricity, computers, and cars. He learned about television and radio, stoves and microwaves. He experienced the luxury of having food so plentiful that you can eat as much as you want, of refrigerators filled with cool drinks, and of packed pantries. He learned about abundance and how it feels to have a full stomach, instead of the dull, constant ache of hunger felt by so many Haitians.

Patrick experienced the love that flowed from those around him, covering him, cradling him, filling his heart. He learned about the kindness of strangers and their willingness to offer a chance to a poor child from a foreign country. He experienced the goodness of mankind, the tenderness of giving hearts, and the willingness of physicians, nurses, and a hospital to reach out to one in need. These lessons cannot be found in a textbook; they are the lessons of life.

Patrick taught us as well. He taught us that the simple things in life are what truly matter. He showed us the beauty and grace of just sitting, of being, whether you talk or not. He taught us about the power of a touch, or a smile, or a wave to a passerby. He taught us the joy of giving and receiving, and it is the ability to do both that makes our existence worthwhile. This is the lesson that we must carry with us as we cope with the frenetic pace of life. By being part of his story, we were each enlarged, expanded, and renewed.

Patrick has returned to Haiti. Although his memories of the specifics of this time will fade, Patrick will never be the same, nor shall we. The tragedy of his life was altered, changed forever by the caring of others. His repair may not last, his physical wounds may never completely heal, but he has been healed in other ways. Patrick and those around him have seen that somewhere, somehow, people do care, do try, do want to help. This type of healing is unbreakable.

We cannot change the world. We cannot make everyone’s situation what we perhaps would like it to be. But if we just try, one life at a time, to show others that there is hope, that others do care, perhaps the world will change around us in ways that we may not see, or truly understand. Improving the human condition one life at a time: this is a story of hope.

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**Dr. Campbell** is a general surgeon in Tampa, FL, and a member of the College’s International Relations Committee.
College responds to young surgeons asking, "What’s in it for me?"

by Gary L. Timmerman, MD, FACS, Sioux Falls, SD
During the June Member Services Committee meeting, my attention was drawn to a list of Fellows who are about to lose their active membership status for a variety of reasons. Remarkably, one in 10 was a surgeon under age 45. As outgoing Chair of the College’s Committee on Young Surgeons, I felt compelled to send each of them a letter inquiring about the reasons for their departure. In this correspondence, I also provided an update on the many endeavors the College has undertaken on their behalf. Their responses conveyed a sense that the College was indifferent to or out of touch with their needs. “What’s in it for me?” they asked. I would like to take this opportunity to share with a broader audience the answer I provided and will continue to give when that question is raised.

Like most Fellows, I joined the College directly after residency, toiling over the two-year-plus application process and the formal, often cold correspondence. At that time, the College’s focus primarily was on academics, and its governance structure was substantially hierarchical. Issues of infection control or AIDS prophylaxis were debated, while the clamoring voices of discontent about managed care organizations, diminishing patient-physician rights, and reductions in reimbursement were forced into the background. The College’s delayed response to these rumblings then led to other specialties (family medicine) taking the lead on such issues as access to care and physician reimbursement. I personally recall “washing my hands” of the College at one point.

**Political rebirth**

However, shortly thereafter, the College experienced a rebirth, realigning its goals and efforts to correspond with its members and their needs. The College appointed a committee to actively comment on the Medicare fee schedule and the formulas used to set payment under it. The immensely dedicated members of what is now known as the General Surgery Coding and Reimbursement Committee serve in key positions on national committees and offer recommendations on how the system could be restructured so that surgeons receive more equitable payment for the services they provide. More importantly, they serve as a voice for surgery at the negotiating table and educate the membership through practice management courses and updates in the Bulletin.

Additionally, the College has expanded the staff and activities of its Washington Office, providing crucial health care information to an often less than receptive federal government. The College’s consistency in advocating for patient rights and access to care has won great respect from legislators. The College’s efforts to achieve national professional liability and tort reform have led to active debate within Congress this year and to the Bush Administration making such reforms a top agenda item.

**Communications**

This “new” College has also ventured beyond the U.S. Postal Service to communicate with its members, having become attentive to the capabilities of the computer age to speed information exchanges. As part of this movement, the College continually redesigns its Web site, making the process of accessing information online more user-friendly.

Additionally, the College recently initiated a Web portal project. The Web portal will allow each member of the College to personalize his or her own homepage based on the individual’s interests, needs, and specialty. This program will provide surgeons with a continual influx of pertinent information relative to their practices, offering daily updates to keep surgeons informed about not only educational activities, but political issues as well (see Dr. Russell’s column and the article on page 28 for more details).

**Young surgeons**

Paramount to all of the College’s efforts of late is its deep interest in the young surgeon. The College has engaged medical students interested in surgery, residents currently in training, and those surgeons just completing their residency through a variety of opportunities and benefits. In recognition of the role that future practicing surgeons will play as this profession continually reinvents itself, Claude H. Organ, Jr., MD, FACS, has sought to make his Presidential term “the year of the resident.”

Furthermore, the College formed the Resident and Associate Society (RAS) (formerly the Candidate and Associate Society) to provide a forum for addressing the needs and concerns of young sur-
geons in training and just entering the field. As the College continues to tailor itself and adapt to the changing needs of individuals embarking on a surgical career, the Board of Governors’ committees, the Board of Regents meetings, and the College’s standing committees are welcoming the active participation of RAS members.

In response to business concerns that young surgeons have, the practice management course faculty has created a CD-ROM for residents. This program is intended to better equip them with a knowledge base in finance and management, subjects too often overlooked in training programs.

The College also has reduced membership dues for residents in acknowledgment of the financial burdens on residents and has streamlined the process for applying for Fellowship so that it only takes one year to complete. All of these efforts were developed to enlighten future surgeons about the benefits of membership and the importance of speaking with a unified voice for the care of the surgical patient.

Professionalism/Competency

The College has also wrestled with the tough issues related to professionalism. A statement addressing the expert witness was submitted to level the playing field in medical lawsuits by ensuring that physicians who testify provide legitimate and knowledgeable information. The College has aggressively sought to engender a high level of competency among young and not-so-young surgeons and to ensure that they are prepared to apply new and emerging technologies. This effort is staffed with skilled instructors who address guidelines, credentialing, and patient safety standards for new devices.

Of course, the issue of competency extends well beyond the facile use of new technology. New measures of competency guidelines will redefine certification and verification for licensure in the future. The College has foreseen the likely direction of this trend and will be prepared to help its membership as the government imposes these new regulations upon us.

Leadership

In June, the Board of Regents met and addressed strategic planning issues in an attempt to be better prepared, positioned, and outspoken to help its members deal with ongoing and emerging challenges. Issues of physician investment, advocacy, communications, education, information technology, member services, and research/optimal patient care were all addressed with bold vision and enthusiasm. Other burgeoning issues include the “restrictive covenants” that are in some contracts and retirement for aging Baby Boomers.

One might expect that all of these endeavors would entail years of development and study, yet the College has implemented many of these efforts in just the past six years. The Committee on Young Surgeons is in step with all of these projects. We have a seat at the table—contributing to, participating in, and suggesting approaches to the organization’s policies.

As I conclude my term as Chair of the Committee on Young Surgeons, I leave inspired, remembering Rome was not built in a day, but it was, indeed, built. This is a new College with an ever-deepening dedication to its changing and increasingly diverse membership and their patients. I ask that each of you stay the course in terms of membership within this organization.

Dr. Timmerman is director of trauma services, a practicing general surgeon, and clinical assistant professor in surgery, Sioux Valley Hospital, University of South Dakota Medical Center, Sioux Falls, SD. He is outgoing Chair of the ACS Committee on Young Surgeons.
The following column is a special feature from What's New in ACS Surgery, the free monthly newsletter from the official textbook of the American College of Surgeons, ACS Surgery: Principles and Practice.

Chylothorax. Larry R. Kaiser, MD, FACS, University of Pennsylvania School of Medicine, Philadelphia.

Although most surgeons’ eyes glaze over at the mention of chylothorax, I have always found this problem fascinating and have spent considerable time thinking about it over the years. After I once made the error in judgment of trying to manage this problem conservatively over the span of several weeks, only to watch the patient slowly deteriorate despite decreasing quantities of drainage, I have taken a much more aggressive approach, with great success.

We see the occasional idiopathic case of chylothorax, in which truly no cause can be found, but in most cases we can readily identify the etiology. Chylothorax may result from: blunt or penetrating trauma; neoplasm infiltrating the mediastinum (usually lymphoma); thrombosis of the left subclavian vein or superior vena cava; or, most commonly, iatrogenic injury at the time of either a pulmonary or esophageal resection or operations in the left inferior neck.

The diagnosis of chylothorax must be confirmed by the unequivocal identification of chyle, the lymphatic drainage of the gut. The presence of chyle is confirmed by a fluid triglyceride level greater than 110 mg/dl. The level may vary depending on the serum triglyceride level and the patient’s diet. Chyle characteristically is milky in appearance, but on occasion, chest lymphatic drainage also has a milky appearance. Thus, not all that is milky is chyle; the elevated triglyceride level cinches the diagnosis.

Chyle is transported from the gut via small lymphatics to the cisterna chyli, a reservoir of sorts that resides on the spine at the first or second lumbar vertebral body and just to the right of the aorta. The thoracic duct, the largest lymphatic channel in the body, arises from the cisterna chyli and passes through the aortic hiatus of the diaphragm into the right chest medial to the azygous vein. The duct remains as a single structure in the inferior aspect of the chest, but as it passes cephalad, it receives numerous lymphatic tributaries from the chest wall.

In most patients, at the level of T4 or T5 it crosses as a single structure into the left chest and continues up into the left neck, where it forms an arch that rises 3 to 4 cm above the clavicle. It then drains into the left subclavian vein near the junction of the subclavian and left internal jugular veins. The duct is subject to injury anywhere along the spine, as well as in the inferior left neck. The difficulty lies in the fact that the duct is difficult to visualize, especially in the midthorax, because of both the size and the thin walls of the branching network and because of the lack of contents in the duct in fasting patients. Following a fat load, the duct...
usually can be visualized along the spine, especially in the inferior aspect of the right hemithorax near the aortic hiatus.

Injury to the duct or branches of the duct occurs when dissection occurs along the spine, especially between the azygous vein and the esophagus. This is especially true during transhiatal esophagectomy, where the duct is rarely, if ever, seen. I’m surprised the incidence of chylothorax following this procedure is not higher than the 2 to 5 percent currently reported. During a left pneumonectomy, the duct may be injured at the level of the aortopulmonary window, because the type of proximal lesions that call for pneumonectomy usually require dissection in this area.

The first clue as to the presence of a chyle leak following esophagectomy is the high output (usually greater than 1,000 ml) from the chest tube. Because the patient is fasting, the drainage is clear or serosanguineous, not milky. Once the patient has resumed a solid diet, the character of the fluid changes markedly, mandating measurement of the triglyceride level of the fluid. Initial treatment involves restricting the diet to clear liquids only and instituting total parenteral nutrition (TPN). If only a small branch of the duct has been injured, this regimen alone may allow for closure of the thoracic duct leak within several days.

Following institution of TPN and the restriction of oral intake to clear liquids only, the chest drainage should once again become clear, and the volume should decrease markedly. As long as the amount of drainage is reasonable—less than 500 ml a day but, preferably, less than 250 ml a day—management can continue in this way with the expectation that the leak will seal. I tend to wait no longer than one week and then proceed to fix the problem, rather than allow the patient to become further depleted of protein and immunosuppressed due to loss of mononuclear cells. The addition of enteral feeding of medium-chain triglycerides, in my experience, rarely is effective in getting these leaks to seal, so we do not use it.

Once the drainage is minimal, the patient should be given a meal containing fat; if the character and volume of the drainage do not change, the chest tube may be removed. Chemical sclerosis of the pleural space adds little and certainly is doomed to fail if it is the primary treatment when drainage is greater than 500 ml a day.

If conservative management, as discussed, fails to resolve the problem within seven days, we use a novel interventional approach to seal the leak. Developed by Stan Cope, this technique begins with a lymphangiogram (almost a lost art in most centers) to allow the cisterna chyli to be visualized and accessed with a percutaneous puncture. A small catheter is then threaded into the thoracic duct, through which fibrin glue and coils are placed to seal the duct, thus eliminating the chylous drainage. We have reported nearly 100 percent success with this technique when the cisterna can be accessed; however, previous extensive upper abdominal surgery usually precludes successful cisternal puncture. Rarely is the procedure successful when the chylothorax results from a lymphoma.

Visualizing and cannulating the cisterna chyli is an interventional radiology tour de force and may not be available in many centers. Standard operative treatment involves ligation of the thoracic duct, usually low within the right hemithorax. No attempt should be made to find and directly ligate the leaking point, as this procedure
is considerably more difficult. Through the eighth or ninth interspace via a limited thoracotomy, all of the tissue on the spine between the azygous vein and the esophagus is ligated as close to the hiatus as possible. Cream or olive oil can be given via a nasogastric tube to help in identifying the duct, but this step is unnecessary, because the duct need not be dissected out. A right-angle clamp should be passed along the spine to ensure that all tissue is included in the mass ligation and that the duct is seen. Successful ligation results in immediate cessation of the chyle leak, with chest tube removal within one or two days.

Alternatively, the method I prefer involves ligation of the duct at the level of the cisterna chyli, where we are assured that the duct is a single structure and no branches will be missed. The aortic hiatus is approached through a small upper midline incision facilitated by excision of the xiphoid process. Cream or olive oil is instilled via a nasogastric tube; the cisterna is easily seen along the spine once the aorta is retracted toward the left. The thoracic duct is ligated at its origin, and the problem is solved. I have found this approach easier than ligation of the duct in the chest as long as the patient has not had previous surgical exposure of the hiatus.

Following thoracic duct ligation, a fatty meal is given to make certain that no chyle leak remains before the chest tube is removed. Thoracic duct ligation has no known detrimental effects. During any procedure in the right chest in which significant dissection occurs along the spine, prophylactic ligation of the duct should be performed near the hiatus, as discussed above.

We rarely pay much attention to the thoracic duct until it becomes a problem; when it does, it is not always easily resolved. Consideration of the anatomic location of the duct and prophylactic ligation when appropriate will serve to limit the time a surgeon will have to spend dealing with this condition.

References

Dr. Sheldon named Editor-in-Chief of ACS Web portal project

ACS Past-President George F. Sheldon, MD, FACS, has been appointed Editor-in-Chief of the College’s Web portal. The project, which emanated from suggestions by the Resident and Associate Society (formerly the Candidate and Associate Society) of the ACS and the Committee on Young Surgeons, was approved by the Board of Regents during its meeting in June.

A Web portal is an electronic delivery system that affords the user a personalized gateway to the Internet. Portals were developed in response to users’ needs to filter information and obtain a quick and easy method of accessing information via the Internet when required. The Web portal project seeks to develop and deploy portal technology for members of the College and to institutionalize a management structure to continue development and enhancement of the portal into the future (see Dr. Russell’s column on page 3 of this issue for additional information about the project).

Dr. Sheldon is Zack D. Owens Professor of Surgery and Social Medicine, and chairman emeritus, department of surgery, University of North Carolina (UNC)-Chapel Hill.

Dr. Sheldon became a Fellow of the College in 1973 and has been an active participant in College activities since that time. He served as ACS President from 1998 to 1999, and as a Regent from 1984 to 1993. As a member of the Board of Regents, he chaired the Communications Committee and was named the first Editorial Advisor for the Bulletin.

Dr. Sheldon was elected to the Board of Governors in 1976 and served on the Executive Committee and as Secretary of the Board of Governors (1979-1982).

Dr. Sheldon has served as president of the American Association for the Surgery of Trauma (1984), the American Surgical Association (1994), and the Visiting Board, Uniformed Services University of the Health Sciences (2002-2004). He served as chairman of the American Board of Surgery (1995) and president of the Society of Surgery Chairs (2000). He is currently a member or emeritus member of the editorial boards for the Journal of the American College of Surgeons, Annals of Surgery, Journal of Trauma, American Journal of Surgery, and SHOCK.

Dr. Sheldon is an Honorary Fellow of the Royal College of Surgeons of Edinburgh, the Royal College of Surgeons of England, the Association of Surgeons of Great Britain and Ireland, the European Surgical Association, Columbian Society of Surgeons, the British Columbia Surgical Society, the Society of Black Academic Surgeons, and the Hunterian Society.

For more information on the Web portal project, contact Dr. Sheldon at george_sheldon@med.unc.edu.

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Kathleen M. Casey, MD, FACS, a general surgeon from Newport, RI, has been appointed to oversee and develop the College’s new volunteerism initiative, Operation Giving Back (OGB). The OGB project is a groundbreaking undertaking that attempts to join the resources of surgeons and volunteer agencies with philanthropic individuals and organizations to better meet the needs of surgically underserved individuals in the U.S. and throughout the world.

The current contributions members of the College make on behalf of medically underserved people are remarkable. Whether volunteering in a clinic down the street or across the globe, or contributing old surgical texts, instruments, or one’s time to help educate a medical student, OGB will work to make it even easier for surgeons to achieve these goals.

An outgrowth of the efforts of the Socioeconomic Affairs Committee of the Board of Governors under the direction of Andrew Warshaw, MD, FACS, and Robert V. Stephens, MD, FACS, OGB will address the needs of ACS Fellows who are either current or prospective volunteers. This initiative will provide the resources they need to find a surgical volunteer opportunity that best fits their individual talents, interests, beliefs, and lifestyle. The project will provide information to help surgeons who wish to volunteer their services but are unsure about issues such as license portability or charitable indemnity.

Dr. Casey obtained a bachelor’s degree in biology from the College of Holy Cross, Worcester, MA, and a medical degree from Dartmouth Medical School, Hanover, NH. She completed a general surgery residency at Virginia Mason Medical Center in Seattle, WA, and then served seven years of active duty with the U.S. Navy in Oak Harbor, WA, Okinawa, Japan, and Newport, RI. A long-standing interest in volunteerism was further strengthened during a deployment to Guatemala in 1998 following Hurricane Mitch. Dr. Casey became a Fellow of the College in 1999.

Fellows attending this year’s Clinical Congress in New Orleans, LA, are invited to visit the OGB exhibit in Lobby I of the Morial Convention Center to learn more about this exciting new volunteerism program. Fellows may obtain updates on key developments in this program as it evolves by adding their name to the OGB database during the Congress.

Additional information may be obtained from Dr. Casey at 401/841-5351 or 312/202-5359.

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Two recent Past-Presidents of the American College Surgeons—R. Scott Jones, MD, FACS, and LaSalle D. Leffall, Jr., MD, FACS—were accorded Honorary Fellowship in the Royal College of Surgeons (RCS) of England during a July 7, 2004, ceremony in London. Joel Cooper, MD, FACS, a Jacobson Innovation awardee, also was admitted into Honorary Fellowship of the RCS(Eng) during the same ceremony.

Both Dr. Jones and Dr. Leffall said that they were extremely honored to have been awarded membership in the RCS(Eng) and expressed sincere gratitude for the hospitality shown them while they were in England.

**Dr. Jones**

“The Honorary Fellowship of the College is an honor reserved for exceptional surgeons,” said Mr. Richard Collins in his citation for Dr. Jones. Mr. Collins said that Dr. Jones’ achievements as an academic surgeon make him well qualified for this special status, noting that his “curriculum vitae inevitably glitters.” Additionally, Dr. Jones has made numerous contributions to the basic science and management of gastrointestinal disease, particularly in relation to the pancreas and hepatobiliary system, Mr. Collins said.

Dr. Jones received his medical degree in 1961 from the University of Texas Medical Branch, Galveston. He then went on to serve first as an assistant instructor of surgery at the Hospital of University of Pennsylvania School of Medicine and then as a clinical investigator for the Veterans Administration Hospital in San Francisco, CA, and as an assistant professor of surgery at the University of California, San Francisco.

After completing his postgraduate training, Dr. Jones served as an associate professor and professor of surgery at Duke University Medical Center, Durham, NC. He then moved to Charlottesville, VA, to accept the position of S. Hurt Watts Professor and chair of the depart-
ment of surgery at the University of Virginia.

Dr. Jones has been an active member of numerous ACS committees, including the Board of Governors, the Surgical Forum Committee, the Program Committee, the Advisory Council for General Surgery, and the Nominating Committee of Fellows. He served as the College's President from 2001 to 2002.

He also has held important positions in many other medical and surgical organizations and has served on the editorial boards of several scholarly publications, including the Journal of the American College of Surgeons. In 1986, he received the Ashbel Smith Distinguished Alumnus Award from the University of Texas Medical Branch.

Currently, Dr. Jones is Director of the ACS Division of Research and Optimal Patient Care, "a title which signals his lifelong commitment to patients," Mr. Collins said.

Dr. Leffall

In presenting the citation for Dr. Leffall, Mr. Anthony Giddings said, "He has had an outstanding research career in surgical oncology, particularly gastrointestinal and breast cancer, contributing to over a dozen books and more than 130 papers," Mr. Giddings said. "His academic achievements have been recognized by the award of honorary degrees from 11 universities.

"His role as a lifelong teacher and communicator remains an inspiration to students, peers, and patients." Mr. Giddings added.

Dr. Leffall graduated summa cum laude from Florida A&M University at age 18 and graduated first in class for his medical degree from Howard University Hospital College of Medicine, Washington, DC, in 1952. He interned at Homer G. Phillips Hospital, St. Louis, MO, and performed residencies at Freedmen's Hospital, Washington, DC, and Washington, DC, General Hospital. He went on to complete a senior fellowship in cancer surgery at Memorial Sloan-Kettering Cancer Center, New York, NY.

After serving from 1960 to 1961 as Captain, Medical Corps., and chief of general surgery, U.S. Army, Dr. Leffall resumed his academic career as professor and chair of the department of surgery at Howard University. In 1992, Dr. Leffall was named the Charles R. Drew Professor of Surgery at Howard.

Dr. Leffall served as Secretary of the College from 1983 to 1992 and as President of this organization from 1995 to 1996. He also has served at the highest levels in numerous other professional organizations and has received many awards of recognition from a number of civic and medical societies. In 1987, the M.D. Anderson Hospital and Tumor Institute, Houston, TX, established the Biennial LaSalle D. Leffall, Jr., Award in honor of his contributions to cancer prevention, treatment, and education in minority and economically disadvantaged communities.

Dr. Cooper

Dr. Cooper was recognized for leading the team that performed the world's first successful lung and double lung transplants. "Professor Cooper has demonstrated the invaluable talent of surgical innovation, and in 1993, he and his colleagues presented their results of a new operation known as 'lung volume reduction surgery' for severe emphysema," said Mr. William Thomas, who offered the citation for Dr. Cooper. For that contribution, Dr. Cooper received the ACS's Jacobson Innovation Award in 1996.

Dr. Cooper received his medical degree from Harvard Medical School in 1964 and completed his surgical residencies at Massachusetts General Hospital, Boston. As part of that training, he spent a year in England, initially as a senior registrar at Frenchay Hospital in Bristol and then as an honorary research assistant at Hammersmith Hospital.

A member of the faculty of Medicine at the University of Toronto, ON, from 1972 to 1988, Dr. Cooper went on to lead that institution's division of thoracic surgery in 1978. He then moved to Washington University, St. Louis, MO, where he was head of general thoracic surgery. In 1997, he was appointed to his current post as the Evarts Graham Professor of Surgery and chief of cardiothoracic surgery at Washington University.

"Professor Cooper has a most prestigious reputation academically and has coauthored over 350 scientific publications," Mr. Thomas added.
College issues revised Statements on Principles

The American College of Surgeons has long had a deep and effective concern for the improvement of patient care and for the ethical practice of medicine. As a result, applicants for Fellowship are evaluated for professional conduct, established reputation, and ethical standing. All Fellows of the College are expected to abide by the College’s Statements on Principles, which outline the Professional Code of Conduct for its members.

At its June 2004 meeting, the Board of Regents approved the first revision of the Statements on Principles in more than a decade. A working group consisting of Roger S. Foster, Jr., MD, FACS (Chair); Barbara L. Bass, MD, FACS; R. Scott Jones, MD, FACS, Director, ACS Division of Research and Optimal Patient Care; John T. Preskitt, MD, FACS; Richard R. Sabo, MD, FACS; Paul E. Collicott, MD, FACS, Director, ACS Division of Member Services; and Barbara L. Dean, Director, ACS Executive Services, was charged with reviewing and revising the Statements to ensure compliance and relevance with the reality of surgical practice today while conforming with the standards and policies of the College.

To review the revised document, visit http://www.facs.org/fellows_info/statements/statements.html. Printed copies are available from the College by calling 312/202-5432.

Disciplinary actions taken

In February 2004, the Board of Regents suspended the Fellowship of Gary J. Lustgarten, a neurosurgeon from North Miami Beach, FL. This suspension will remain in effect until the final resolution of his disciplinary action in the state of North Carolina. Dr. Lustgarten has been charged with violation of Article VII, Section 1(b) of the ACS Bylaws. This action follows disciplinary action in the state of North Carolina that imposed a limitation on Dr. Lustgarten’s medical license in response to his testimony as an expert witness in a medical malpractice lawsuit.

The following disciplinary actions were taken by the Board of Regents at their June 12, 2004, meeting:

- A general surgeon from Louisville, KY, was placed on probation with the College until such time as he has a full and unrestricted license to practice medicine; until he has full and unrestricted surgical privileges in an accredited hospital; and until his practice pattern has been reviewed and approved by the Central J udiciary Committee. He had been charged with violation of Article VII, Section 1(b) of the Bylaws of the College. The action followed disciplinary action by the Kentucky Medical Board that has placed his license on probation for 51 months with terms and conditions based on findings that he engaged in dishonorable, unethical, or unprofessional conduct based on improper touching of patients and staff.
- Howard D. Markowitz, an orthopaedic surgeon from Lexington, KY, was expelled from the College. He had been charged with violation of Article VII, Sections 1(b) and (f) of the Bylaws following disciplinary actions by the New York, New Jersey, and Kentucky medical boards. He voluntarily surrendered his licenses in New Jersey and New York. His license in Kentucky was placed on probation for 51 months with terms and conditions based on findings that he engaged in dishonorable, unethical, or unprofessional conduct based on improper touching of patients and staff.
- Gerald Moss, a general surgeon from White Plains, NY, was expelled from the College following charges that he violated Article VII, Sections 1(b) of the Bylaws. Dr. Moss’ license to practice medicine in the state of New York was revoked August 16, 1993, following a finding of gross negligence, negligence on more than one occasion, and failure to maintain accurate records.
ANZ Travelling Fellowship available

The International Relations Committee of the American College of Surgeons announces the availability of a travelling fellowship, the Australia and New Zealand (ANZ) Chapter of the American College of Surgeons Travelling Fellowship.

**Purpose**
The purpose of this fellowship is to encourage international exchange of information concerning surgical science, practice, and education and to establish professional and academic collaborations and friendships.

**Basic requirements**
The scholarship is available to a Fellow of the American College of Surgeons in any of the surgical specialties who meets the following requirements:
- Has a major interest and accomplishment in basic sciences related to surgery.
- Holds a current full-time academic appointment in Canada or the U.S.
- Is under 45 years of age on the date the application is filed.
- Is enthusiastic, personable, and possesses good communication skills.

**Activities**
The Fellow is required:
- To spend a minimum of two or three weeks in Australia and New Zealand before or after the Annual Scientific Congress of the Royal Australasian College of Surgeons to lecture and to share clinical and scientific expertise with the local surgeons.
- To attend and address the ANZ Chapter meeting during that congress.
- To visit at least two medical centres in Australia and New Zealand.
- To participate in the formal convocation ceremony of that congress.

In the event that the selected applicant is from a surgical specialty that is not participating in the RACS Congress, specific negotiations will be necessary to ensure the Travelling Fellow’s participation in a national meeting of that specialty.

The academic and geographic aspects of the itinerary will be finalized in consultation and mutual agreement between the Fellow and the President or designated representative of the ANZ Chapter of the American College of Surgeons. The surgical centres to be visited depend to some extent on the special interests and expertise of the Fellow and his or her previously established professional contacts with surgeons in Australia and New Zealand.

His or her spouse is welcome to accompany the successful applicant. There will be many opportunities for social interaction, as well as these professional activities.

**Financial support**
The ANZ Chapter and the College will provide the sum of $12,000 U.S. to the successful applicant, who will also be exempted from registration fees for the Annual Scientific Congress. He or she must meet all travel and living expenses. Senior chapter representatives will consult with the Fellow about the centres to be visited in Australia and New Zealand, the local arrangements for each centre, and other advice and recommendations about travel schedules. The Fellow is to make his own travel arrangements in North America, as this makes available to him reduced fares and travel packages for travel in Australia and New Zealand.

The American College of Surgeons’ International Relations Committee will select the Fellow after review and evaluation of the final applications. A personal interview may be requested prior to the final selection.

Applications for this travelling fellowship may be obtained from the College’s Web site at www.facs.org, or by writing to the International Liaison Section, American College of Surgeons, 633 N. Saint Clair St., Chicago, IL 60611-3211.

The closing date for receipt of completed applications is November 15, 2004. The successful applicant and an alternate will be selected and notified by March 2005.
The Association of Women Surgeons (AWS) will award its 2004 Distinguished Member Award to Linda Brodsky, MD, FACS, during the organization’s national meeting this month in New Orleans, LA. Dr. Brodsky was selected for this honor because she “has been a tireless advocate for women in surgery and for our association,” according to Vivian Gahton, MD, FACS, president of the AWS. Dr. Brodsky is director of the department of pediatric otolaryngology at Women and Children’s Hospital of Buffalo, NY.

Ricardo L. Carrau, MD, FACS, and Carl H. Snyderman, MD, FACS, both associate professors of otolaryngology at the University of Pittsburgh (PA) School of Medicine, received presidential citations from the American Head & Neck Society. The Fellows were recognized during the Sixth International Conference on Head and Neck Cancer in Washington, DC, for their “leadership in minimally invasive and endoscopic techniques” for surgery of the sinuses and skull base.

Claude H. Crockett, Jr., MD, FACS, served as a guest speaker at the 21st International Congress of the French Society of Aesthetic Surgery, which took place May 13-16 in Paris. His featured presentation was Brow and Forehead Lifting—A 20-Year Experience. Dr. Crockett is an otolaryngologist in private practice with Cosmetic Surgery Associates of the Tri-Cities, Bristol, TN.

Francis L. Delmonico, MD, FACS, has been elected vice-president/president-elect of the board of directors of the United Network for Organ Sharing, which manages the nation’s Organ Procurement and Transplantation Network under a federal contract. Dr. Delmonico is currently medical director of the New England Organ Bank in Newton, MA, and professor of surgery at Harvard Medical School in Boston. He serves on the Secretary of Health and Human Services’ Advisory Committee on Organ Transplantation, chairing its subcommittee on clinical issues, and is a past recipient of the Distinguished Service Award of the National Kidney Foundation and the American Society of Transplantation.

The World Journal of Surgery has appointed John G. Hunter, MD, FACS, to serve as editor-in-chief. Dr. Hunter is
MacKenzie Professor and chair of the department of surgery at Oregon Health Science University School of Medicine, Portland, and a recognized expert and innovator in minimally invasive surgery. The World Journal of Surgery is published by the International Society of Surgery.

In recognition of his dedication to building a statewide trauma system, Sidney Miller, MD, FACS, has been named the Frederick A. White Distinguished Professor of Service at Wright State University, Dayton, OH. Dr. Miller devoted more than two decades to advocating for a trauma system in Ohio to ensure that injured patients are directed to appropriate facilities. After legislation passed in 2000, Gov. Bob Taft (R) appointed Dr. Miller to serve on the Ohio Trauma Committee established by the bill. Dr. Miller is professor of surgery at Wright State University and director of the Regional Adult Burn Center at Miami Valley Hospital.

Carl Patow, MD, MPH, FACS, has received a Bush Foundation Medical Fellowship to conduct a three-year study leading to the redesign of the graduate medical education system in Minnesota. The new model will emphasize patient safety, informatics, communication, health care design, and teamwork. Dr. Patow is executive director of the HealthPartners Institute for Medical Education and associate dean of the University of Minnesota Medical School for Faculty at HealthPartners in Minneapolis. He also is an associate professor of otolaryngology at the University of Minnesota Medical School. The Bush Medical Fellows Program provides grants to physicians who are seeking to improve health care in Minnesota, North Dakota, and South Dakota.

Krishna Sawhney, MD, FACS, was recently named the 2004-2005 president of the American Medical Association (AMA) Foundation. Dr. Sawhney is chief of surgery for the Downriver region of the Henry Ford Health System and clinical associate professor of surgery at Wayne State University School of Medicine, Detroit, MI. The AMA Foundation supports a wide range of programs intended to improve health care in the U.S., providing scholarships for medical students, grants for research and community-based programs, and educational resources.

Capt. David S. Wade, MD, FACS, recently assumed command of the U.S. Naval Medical Clinic, Patuxent River, in Maryland. Dr. Wade is a Hayward Award-winning graduate of the Naval War College and is associate professor of clinical surgery at the Uniformed Services University of the Health Sciences, Bethesda, MD.

RESIDENT WORK HOURS, from page 16

Kestle J: Tracking resident work hours. AANS Bull, Fall 2003, 49.
Claims coding reference and education database

ACS CodingToday features:

- Complete CPT, HCPCS Level II, and ICD-9 codes.

- Current Medicare Correct Coding Initiative bundling edits, national and local fee schedules, and Medicare policy information.

- Medicare information on global fee days and modifier usage.

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- Full text Local Medical Review Policies, fall 2003.

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Advances in Trauma seminar scheduled for December

The College’s Committee on Trauma, Region VII (Iowa, Kansas, Missouri, and Nebraska) is sponsoring the 27th annual Advances in Trauma seminar December 10-11 at the Westin Crown Center in Kansas City, MO.

The regional and state chairs have planned a program that will benefit all physicians involved in trauma patient care. Program chairs are: R. Stephen Smith, MD, FACS, Chief, Region VII; Philip R. Caropreso, MD, FACS, Iowa State Chair; Lee V. Ludwig, MD, FACS, Kansas State Chair; Thomas S. Helling, MD, FACS, Missouri State Chair; Reginald A. Burton, MD, PhD, FACS, Nebraska State Chair; and Frank L. Mitchell, Jr., MD, FACS, Program Co-Chair.

The objective of this continuing medical education course is to present nationally recognized faculty who will discuss timely trauma and critical care issues aimed at improving care of the acutely injured patient. Current trauma diagnostic and therapeutic techniques will provide the audience with the most up-to-date information available.

The Friday program will include the following presentations: Rural Trauma Symposium: Optimal Patient Transport in the Rural Setting, and Destinations: Where Should the Patient Go?; Bleeding You Can Hear: Injury to the Hepatic Veins and Inferior Vena Cava; The New FAST Exam: Ultrasound of the Abdomen and Thorax; Complex Injury to the Esophagogastric Junction; Who Is in Charge in the ICU? Surgeons, Intensivists, or e-Intensivists?; The Complete Trauma Surgeon: The European Model; The Crush Syndrome; Trauma Care at Mach 25; Thoracic Outlet: Vascular Injury—Tricks of the Trade; DVT Prophylaxis: Why, When, Where and How; Penetrating Abdominal Trauma: Are Diagnostic Tests Needed?; and Case Review from Region VII.

Saturday’s program continues with: Rural Trauma Symposium: The Rural Trauma Team Development Course, and The Effect of the Litigation Crisis on Rural Trauma Care; Endovascular Repair in Vascular Trauma; Scoring Systems: Why Bother?; Trauma and Pregnancy; The Abdominal Compartment Syndrome; New Directions in Trauma Training: The Emergency/Critical Care Surgeon: Universal Coverage: Are We Ready?; Milestones in Trauma; Lessons from the ER; Post-Traumatic Stress Disorders in Children following Trauma; Trauma in the Elderly; Continuity of Care in the Era of the 80-Hour Workweek; and Cases for Region VII: Stump the State Chairs.

Faculty members include: ACS Regent L.D. Britt, MD, MPH, FACS; Dr. Burton; Dr. Caropreso; Lawrence N. Diebel, MD, FACS; Scott A. Dulchavsky, MD, PhD, FACS, FCCM; David V. Feliciano, MD, FACS; Thomas M. Foley, MD, FACS; William R. Fry, MD, FACS; Dr. Helling; Gregory J. Jurkovich, MD, FACS; Dr. Ludwig; Arthur L. Kellermann, MD, MPH; M. Margaret Knudson, MD, FACS; Kenneth L. Mattox, MD, FACS; Dr. Mitchell; Dr. Smith; Gregory A. Timberlake, MD, FACS; and Donald D. Trunkey, MD, FACS.

Additional information may be obtained via the ACS Web site at www.facs.org.

Trauma meetings calendar

The following Continuing Medical Education Courses in Trauma are cosponsored by the American College of Surgeons Committee on Trauma and Regional Committees:

• Advances in Trauma, December 10-11, 2004, Kansas City, MO.
• Trauma and Critical Care—2005, March 21-23, 2005, Las Vegas, NV.
• Trauma and Critical Care—2005: Point/Counterpoint XIV, June 6-8, 2005, Atlantic City, NJ.

Complete course information can be viewed online (as it becomes available) through the American College of Surgeons Web site at: http://www.facs.org/trauma/cme/traumtgs.html, or contact the Trauma Office at 312/202-5342.
NTDB™ data points
“A is for airway”

by Richard J. Fantus, MD, FACS, Chicago, IL, and John Fildes, MD, FACS, Las Vegas, NV

From the time that we are children in kindergarten, we are taught the importance of learning our ABCs. In 1980, this concept was carried over to the care of the traumatized patient with the advent of the American College of Surgeons’ Committee on Trauma-sponsored Advanced Trauma Life Support Course® (ATLS®). ATLS stresses the importance of a logical and reproducible approach to the initial evaluation and treatment of the trauma patient. By recognizing the fact that injury kills in a certain reproducible timeframe, the development of the “ABCDE” approach to the evaluation and treatment of the injured patient was developed. The first and foremost threat to life is the loss of an airway: “A” is for airway.

When looking for a subset of patients that are prone to have airway compromise, patients with significant head injury come to mind. The provision of a secure airway and the maintenance of oxygenation and ventilation are important factors in the prevention of secondary brain injury. As a result of the widespread application of the principles of ATLS, which emphasize the airway and outline methods for chemically assisted intubation, we have made great strides in the provision of trauma care within our hospitals. In reviewing the records of patients with a diagnosis code for head injury and a Glasgow Coma Score of eight or less contained in the National Trauma Data Bank’s Annual Report 2003, there are 40,020 patients that had endotracheal intubation documented as either being performed in the emergency department or in the prehospital setting. These data are depicted in the graph on this page.

It is not surprising to find that, as hospital care of the injured patient improves, some of these concepts and techniques are attempted in the prehospital arena. If a definitive airway is important, is there a role for pharmacological adjuncts in the field to increase the number of prehospital intubations? There have been several recent studies addressing the safety and efficacy of rapid sequence intubation for prehospital airway control. At present, questions remain and additional outcomes-based research is needed. However, we must not forget the basic adjuncts to airway control, such as chin lift and jaw thrust, that any one of us can perform in any location, at any time, if the need arises.

Throughout the year, we will be highlighting these data through brief monthly reports in the Bulletin. For a complete copy of the National Trauma Data Bank’s Annual Report 2003, visit us online at our new Web address: http://www.ntdb.org. If you are interested in submitting your trauma center’s data, contact Melanie L. Neal, Manager, NTDB, at mNeal@facs.org.
Chapter news

by Rhonda Peebles, Division of Member Services

To report your chapter’s news, contact Rhonda Peebles toll-free at 888/857-7545, or via e-mail at rpeebles@facs.org.

College and New York Chapter form Manhattan Council

In May 2004, the ACS Board of Governors’ Executive Committee officially created the Manhattan Council and assigned members of the College with a Manhattan mailing address to the New York Chapter. The Manhattan Council was developed to remedy problems with the College’s organizational structure in the area. The New York Chapter will manage the Manhattan Council through an affiliation agreement that provides for:

1. Complying with all federal and state laws regarding organizational matters including: Internal Revenue Service regulations; statetax, finance, and lobbying laws; and rules established by the New York Department of State and Attorney General.
2. Staffing the office and facilitating communications among the Fellows.
3. Participating in coalitions with medical societies.
4. Maintaining a database of members in New York State, which can be used to facilitate communications among the members through e-mail, fax, or standard surface mail.
5. Conducting lobbying activities.
6. Administering a political action committee to augment the chapter’s advocacy activities.

ACS members in Manhattan who would like more information or to volunteer should contact Heather G. Bennett, JD, Executive Director, at 518/433-0397, or via e-mail at bennett@bennettfirm.com.

In other news, on June 4, the NY Chapter hosted a meeting of program directors, which was chaired by James Peacock, MD, FACS, University of Rochester. The purpose of the meeting, which was held in New York City, was to familiarize program directors with the audit process for resident work hours and with resources available from the New York State Council on Graduate Medical Education.

Chapter anniversaries

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Alabama Chapter meets

The Alabama Chapter met at Point Clear, June 10-12, and N. F. McGowin III, MD, FACS, was elected President. This year’s program was coordinated by Charles B. Rodning, MD, PhD, FACS. It featured guest speakers from Washington, DC, and North Carolina, as well as visiting professors from Brown University, Providence, RI, the University of California-San Francisco, and the University of Michigan, Ann Arbor.
Lebanon Chapter publishes first newsletter

Under the direction and leadership of Michel Daher, MD, FACS, the Lebanon Chapter has published its first newsletter. Dr. Daher serves as President of the Lebanon Chapter, and, during his term, he hopes to increase communications among the Fellows in Lebanon. The first edition of the newsletter featured a brief history of the Lebanon Chapter, which was founded by Farid Sami Haddad, MD, FACS, in 1963; the Lebanon Chapter received its charter in 1964. A copy of this chapter’s first newsletter has been placed in the College’s official Archives, and is available online at http://www.facslebanon.org.

Introducing an important monthly series addressing end-of-life issues, written for and by members of the Surgeons Palliative Care Workgroup and published in the Journal of the American College of Surgeons. Of special note is the October 2003 article, “The Surgeons Palliative Workgroup Report from the Field.”